STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E247		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPI 04/27	LETED			
	PROVIDER OR SUPPLIER HERMITAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N 17TH AVE BEECH GROVE, IN 46107						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE			
	This visit was for a Recertification and State Licensure Survey. Survey Dates: April 23, 24, 25, 26, and 27, 2012 Facility Number: 000391 Provider Number: 15E247 AIM Number: 100274990 Survey Team: Beth Walsh, RN-TC Courtney Mujic, RN Karina Gates, MS Barbara Hughes, RN (April 25th and 26th) Census Bed Type: NF: 48 Residential: 33 Total: 81 Census Payor Type: Medicaid: 28 Other: 53 Total: 81 Residential Sample: 7 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F0000						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000391

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/31/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E247		A. BUILDING B. WING	00	COM 04/2	(X3) DATE SURVEY COMPLETED 04/27/2012	
PROVIDER OR SUPPLIE L HERMITAGE	R	501 N 1	7TH AVE	CODE		
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Quality review	completed on May 2,					
	PROVIDER OR SUPPLIE L HERMITAGE SUMMARY S (EACH DEFICIENT REGULATORY OF	OF CORRECTION IDENTIFICATION NUMBER: 15E247 PROVIDER OR SUPPLIER	OF CORRECTION IDENTIFICATION NUMBER: 15E247 PROVIDER OR SUPPLIER L HERMITAGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Quality review completed on May 2,	OF CORRECTION IDENTIFICATION NUMBER: 15E247 A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIF 501 N 17TH AVE BEECH GROVE, IN 46107 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Quality review completed on May 2,	OF CORRECTION IDENTIFICATION NUMBER: 15E247 A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 501 N 17TH AVE BEECH GROVE, IN 46107 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Quality review completed on May 2,	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		a. Building 00			COMPLETED		
		15E247	B. WING			04/27/	2012
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NAME OF P	ROVIDER OR SUPPLIER			501 N 1	7TH AVE		
ST PAUL	HERMITAGE				GROVE, IN 46107		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0280 SS=D	483.20(d)(3), 483 RIGHT TO PART CARE-REVISE OF The resident has incompetent or or incapacitated unparticipate in plath changes in care A comprehensive developed within of the comprehensive developed within of the comprehension of the comprehension of the comprehension of the comprehension of the resident's practicable, the participate staff by the resident's far representative; are revised by a tear each assessment. Based on interview, the facing resident's fall or quarterly assess reflect the residents review who met the crick (Resident #12) Findings include The clinical recovery was reviewed or a.m.	3.10(k)(2) TICIPATE PLANNING CP Is the right, unless adjudged otherwise found to be der the laws of the State, to nning care and treatment or and treatment. The care plan must be a range of the completion ansive assessment; prepared linary team, that includes the ian, a registered nurse with the resident, and other in disciplines as determined needs, and, to the extent participation of the resident, mily or the resident's legal and periodically reviewed and m of qualified persons after int. The view and record lity failed to revise a grament to accurately dent's status for 1 of 3 wed in the sample of 3 iteria for falls.	F028		Care plan for resident #12 was reviewed and fall care plan wa updated to reflect resident's current assessment- identified condition and needs on 4/27/1 including goal change tha resident be free of injury associated with falls in next 90 days. Direct care staff was informed by written care plan summary located in hall ADL k MDS/CP RN will review care plans of assessment-identified residents with fall risk scores of 10 or greater and those with fawithin the past 180 days for accuracy and relevance and update as needed by 5/27/12. MDS/CP RN and unit manager	s 2, og. of alls	05/27/2012
	THE diagnoses	IUI RESIDEIIL#12			RN will review post-fall		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
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		15E247	B. WING			04/27/	2012
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	. HERMITAGE			BEECH	GROVE, IN 46107		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG		R LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	· ·	vere not limited to:			investigation report and add identified intervention to fall ca	uro.	
		on, degenerative joint			plan and staff care plan summ		
		tension, constipation,			by 5/27/12. MDS/CP RN will	idi y	
	hypoglycemia,	anemia, and			utilize post fall investigation		
	osteoarthritis.				reports and 24 hour reports to		
					formulate accurate fall care pla		
	The 4/3/12 gua	arterly MDS (Minimum			and will communicate change		
		essment indicated			staff by revised written care pl		
	l '	vas at risk for falls, had			summaries in hall ADL logs. A	4	
		with no injury, and 0			fall investigation report is completed after each fall (See		
	falls with injury				attached fall investigation repo		
					This is forwarded to the MDS/		
	assessment or	I I/IU/IZ.			RN who then updates the care		
					plan, prints a copy of the same		
		cord indicated Resident			(see attached) and places it in	the	
		during the quarter			staff ADL log. (The ADL log		
	between the 1/	10/12 MDS			contains elimination tracking		
	assessment ar	nd the 4/3/12 MDS			forms, CNA ADL charting, restorative care flowsheets, fu	П	
	assessment.	One fall was on			and quarterly assessment care		
	1/29/12, and th	ne other fall was on			plans all revised updated	-	
	2/22/12.				careplans and social service		
					pre-admit summaries). Pertine		
	The most recei	nt falls care plan was			staff are notivied by the MDS/	CP	
		n and provided by RN			RN via Interdepartmental		
		· · · · · · · · · · · · · · · · · · ·			Communication sheets (see		
		at 2:00 p.m. The care			attached) of updated care plar in ADL log. System will be	ıs	
	•	a review date of			reviewed and evaluated in		
		"next review" date of			quarterly QA committee meeti	ngs	
		are plan indicated the			for one year. A flow sheet for f		
	problem was Resident #12 had fallen 6 times during the quarter. The problem also referenced a fall on 11/26/11 in which the resident				care plan update distribution (see	
					attached) will be used by the		
					MDS/CP RN to monitor the		
					efficacy of the system.	a zill	
	sustained a 1 d	cm laceration over his			Corrections described above to be completed by 5/27/12	WIII	
		goal was for the			DC COMPICION BY SIZITIZ		
	resident to be f	_					

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	IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A DULL DDG 00			(X3) DATE SURVEY COMPLETED	
	15E247		A. BU B. WII	ILDING			7/2012
			D. WII		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				7TH AVE		
ST PAUL	HERMITAGE			BEECH	GROVE, IN 46107		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG				PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE	COMPLETION DATE
1710		w with RN #3 on		1710	·		DATE
	_	0 a.m., she indicated					
		ident #12's fall care					
	-	falling 6 times in the					
	quarter was no						
		are plan goal should					
		reduced injury from be free of falls as the					
		ated. She indicated					
	=	dated the care plan					
		sessment reference					
		are plan meeting date.					
		hink I forgot to update					
	the care plan."						
	3.1-35(d)(2)(B)						
	J. 1-JJ(U)(Z)(D)						
							1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A RIHI DING 00		00	COMPLETED	
	15E247	A. BUILDING			04/27/	2012
		D. WIIV		ADDRESS CITY STATE ZIP CODE		
OVIDER OR SUPPLIER						
ST PAUL HERMITAGE						
SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
`				CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
483.25(h) FREE OF ACCIE HAZARDS/SUPE The facility must environment rem hazards as is pos receives adequat assistance device Based on obsel record review, t ensure precauti prevent a fall ar falls for 1 of 3 re sample of 3, wh falls. (Resident Findings include The clinical rece was reviewed of a.m. The diagnoses included, but we bilateral total kr macular degene dementia-Alzhe delusions and a In a record revie investigation fro a.m., received f on 4/26/12 at 1 indicated that a	DENT ERVISION/DEVICES ensure that the resident ains as free of accident esible; and each resident te supervision and es to prevent accidents. rvation, interview, and the facility failed to ions were in place to and further potential esidents reviewed in a ano met the criteria for at #21) e: ord for Resident #21 on 4/25/12 at 11:30 for Resident #21 ere not limited to: anee replacement, eration, senile esimer's type with agitation. ew of the fall om a fall on 4/8/12 at 1 from the Unit Manager 1:00 a.m., the report new intervention was	F03	TAG 23	Care plan for resident #21 was reviewed and fall care plan wa updated to reflect resident's current assessment-identified condition and needs on 4/27/1 including intervention for staff check walker placement in roo frequently as resident consiste places it in location not within reach and is cognitively unable remember to do so. Staff will place non-skid socks on reside each HS and track same on treatment administration record Direcvt care staff was informed by written care plan summary located in hall ADL log. MDS/RN will review care plans of assessment-identified resident with fall risk scores of 10 or greater and those with falls with past 180 days for accuracy and relevance and update as need by 5/27/12. MDS/CP RN and unit manager RN will review post-fall investigation report and add identified intervention to facare plan and staff care plan summary by 5/27/12. MDS/CF RN will utilize post fall investigation reports and 24 horses	S S S S S S S S S S S S S S S S S S S	DATE 05/27/2012
Erekfef F – Vá – ikroo liáoit	SUMMARY ST (EACH DEFICIENCE REGULATORY OR 483.25(h) FREE OF ACCIE HAZARDS/SUPE The facility must environment reme hazards as is post receives adequat assistance device Based on obsete or ecord review, the sample of 3 resident of 3 resident of 3 resident or experience of 3 resident or experience of 3 resident of 3 resident or experience or experience of 3 resident or experience of 3 resident or experience or e	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure precautions were in place to prevent a fall and further potential falls for 1 of 3 residents reviewed in a sample of 3, who met the criteria for falls. (Resident #21) Findings include: The clinical record for Resident #21 was reviewed on 4/25/12 at 11:30	DVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure precautions were in place to prevent a fall and further potential falls for 1 of 3 residents reviewed in a sample of 3, who met the criteria for falls. (Resident #21) Findings include: The clinical record for Resident #21 was reviewed on 4/25/12 at 11:30 a.m. The diagnoses for Resident #21 included, but were not limited to: bilateral total knee replacement, macular degeneration, senile dementia-Alzheimer's type with delusions and agitation. In a record review of the fall investigation from a fall on 4/8/12 at 1 a.m., received from the Unit Manager on 4/26/12 at 11:00 a.m., the report indicated that a new intervention was to be implemented after the fall. The	DVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure precautions were in place to orevent a fall and further potential falls for 1 of 3 residents reviewed in a sample of 3, who met the criteria for falls. (Resident #21) Findings include: The clinical record for Resident #21 was reviewed on 4/25/12 at 11:30 a.m. The diagnoses for Resident #21 ncluded, but were not limited to: bilateral total knee replacement, macular degeneration, senile dementia-Alzheimer's type with delusions and agitation. In a record review of the fall nevestigation from a fall on 4/8/12 at 1 a.m., received from the Unit Manager on 4/26/12 at 11:00 a.m., the report indicated that a new intervention was to be implemented after the fall. The	DYIDER OR SUPPLIER #ERMITAGE SUMMARY STATEMENT OF DEFICIENCIES (#EACH DEFICIENCY MUST BE PERCEDED BY FULL. REGULATORY OR LSC IDENTIFYING INFORMATION) ### REGULATORY OR LSC IDENTIFYING INFORMATION ### REGULATORY OR LSC IDENTIFY INFORMATION ### REGULATORY OR LSC IDENTIFY ### REGU	STRIET ADDRESS, CITY, STATE, ZIP CODE SOTION 1 77TH AVE BEECH GROVE, IN 46107 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICENCY MUST BE PERCEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to provent a fall and further potential falls for 1 of 3 residents reviewed in a sample of 3, who met the criteria for falls. (Resident #21) Findings include: The clinical record for Resident #21 was reviewed on 4/25/12 at 11:30 a.m. The diagnoses for Resident #21 nocluded, but were not limited to: oblateral total knee replacement, macular degeneration, senile dementia—Alzheimer's type with delusions and agitation. In a record review of the fall investigation from a fall on 4/8/12 at 1 a.m., received from the Unit Manager on 4/26/12 at 11:00 a.m., the report indicated that a new intervention was to be implemented after the fall. The

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		I DING	00	COMPLETED	
		15E247	A. BUILDING B. WING 04/27/20			04/27/2012	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹			7TH AVE		
ST PAUL	ST PAUL HERMITAGE				GROVE, IN 46107		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	A fall care plant intervention was Fr's [Father's] reach and rem when ambulati sure Father had non-skid socks. In a fall investig 4/18/12 at 9:30 the Unit Managa.m., the report Resident #21 was regular socks. On 4/26/12 at interview with Find Resident #21 was obsert his walker near	sisted to bed at night. In, dated 4/17/12, one as, "The staff will keep walker within easy ind him often to use it ing. The staff will make is his shoes on or son." In gation, from a fall on in in p.m., received from in			written care plan summaries in hall ADL logs. System will be reviewed and evaluated in quarterly QA committee meeti for one year. MDS/CP RN wutilize post fall investigation reports and 24 hour reports to formulate accurate fall care pland will communicate changes staff by revised written care pland summaries in hall ADL logs. A investigation report is complet after each fall (See attached fainvestigation report). This is forwarded to the MDS/CP RN who then updates the care pland prints a copy of the same (see attached) and places it in the staff and places it in the staff and quarterly assessment care plans all revupdated careplans and social service pre-admit summaries) Pertinent staff are notified by the MDS/CP RN via Interdepartmental Communication sheets (see attached) of updated care plan in ADL log. System will be reviewed and evaluated in quarterly QA committee meetifor one year. A flow sheet for the care plan update distribution (attached) will be used by the MDS/CP RN to monitor the efficacy of the system. All corrections described above we be completed by 5/27/12.	ngs rill ans s to an fall ed all an, staff as IA ised . the	
	#21 was obser	ved lying in bed, with r the opposite wall and			corrections described above w		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	OI CORRECTION	15E247	A. BUILDING	00	04/27/2012
			B. WING STREE	T ADDRESS, CITY, STATE, ZIP CODE	1
NAME OF I	PROVIDER OR SUPPLIE	R		I 17TH AVE	
ST PAUL	HERMITAGE		BEEC	CH GROVE, IN 46107	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
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TAG	Resident #21 v bed, on 4/26/1 walker near the same spot as to observations a reach. During an inter 4/26/12 at 2:57 that Resident # walker near him reach. When contained the observation #2 indicated the would go move resident. On 4/27/12 at #21 was observation #21 was observation #21 was observation #221 was observation #221 was observation #23 was observation #2421 was observation #25 was observation #25 was observation #25 was observation #25 was observation was observation.	was observed lying in 2 at 2:55 p.m., with his e opposite wall, as the the previous and not within easy exiew with LPN #2, on 7 p.m., she indicated #21 should have his m and within easy queried why the walker for the resident during has of the resident, LPN at she didn't know and the the walker near the exident wed lying in bed, with rethe opposite wall and	TAG	CROSS-REFERENCED TO THE APPROP	RIATE CONNELLTION DATE

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E247			(X2) MULTIPLE Co	00		LETED		
		100271	B. WING 04/27/2012 STREET ADDRESS, CITY, STATE, ZIP CODE					
NAME OF P	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP C 17TH AVE	CODE			
ST PAUL	HERMITAGE			H GROVE, IN 46107				
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